

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2011
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2026 EAST 54TH STREET INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates July 5 & 6, 2011.</p> <p>Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330</p> <p>Survey Team: Courtney Hamilton, RN TC Connie Landman, RN Diana Zgnoc, RN Christi Davidson, RN</p> <p>Census Bed Type: Residential: 72</p> <p>Census Payor Type: Other: 72</p> <p>Residential sample: 5</p> <p>American Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed on July 7, 2011 by Bev Faulkner, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1